HEALTH RECORD

Massachusetts Department of Mental Retardation

Completed By:
Relationship to Individual:
Date:

(To be completed or updated at the ISP and brought to all new medical contacts)

Name _____ **Likes to be called** _____

D.O.B. _____ **Soc. Sec #** _____ **Religion:** _____

Address _____

_____

Tel. # _____

Health Insurance (type & numbers)

Primary: _____

Secondary: _____

Agency Responsible for Providing Care? ☐ **No** ☐ **Yes** _____ **Tel. #** _____
(Name of agency/Primary contact person)

Consent Status: ☐ Can give own consent ☐ Consent from guardian ☐ **Unable to give own consent and no guardian** Name _____ Tel. # _____

Resuscitation Status: ☐ DNR ☐ Full Resuscitation If DNR, is comfort care form available? ☐ Yes ☐ **No** ☐ Unknown

Health Care Proxy ☐ **No** ☐ Yes Name _____ Tel. # _____

Emergency Contacts

#1 Name _____

Tel. _____

#2 Name _____

Tel. _____

Medications: ☐ Medication sheet/record attached Or ☐ List attached

Pharmacy: Name: _____ Tel: _____

Address: _____

Allergies: Medications: _____

Food/Environmental: _____

Type of Reaction: _____

Current Medical Problems & Diagnoses:

_____

_____

_____

_____

Communication:
- ☐ Able to Communicate
- ☐ Communication Difficulties/Uses Verbalizations
- ☐ Communication Difficulties/Uses Gestures
- ☐ Not Able to Communicate Needs
- ☐ Unable to Use Call Bell

Vision:
- ☐ Normal
- ☐ Low Vision
- ☐ Blind
- ☐ Wears Glasses

Hearing:
- ☐ Normal
- ☐ Hard of Hearing
- ☐ Deaf
- ☐ Hearing Aid

Supportive Devices:
- ☐ Padded side rails
- ☐ Splints
- ☐ Braces
- ☐ Helmet
- ☐ Other _____

Toileting Ability:
- ☐ Continent
- ☐ Needs Assistance
- ☐ Incontinent
- ☐ Catheterized
- ☐ Other _____

Medication Administration:
- ☐ Independent/Self Medicates
- ☐ Medication Administered by Staff

Dining/Eating:
- ☐ Independent
- ☐ Needs Assistance
- ☐ Totally Dependent
- ☐ Fed Through a Tube
- ☐ Other _____

Diet Texture:
- ☐ Regular
- ☐ Chopped
- ☐ Ground
- ☐ Puree
- ☐ Thicken Liquid

Diet Type: _____

_____

Ambulation:
- ☐ Independent ☐ Steady ☐ Unsteady
- ☐ Needs Assistance ☐ 1 person ☐ 2 people
- ☐ Ambulation Aids ☐ Walker ☐ Cane ☐ Crutches
- ☐ Wheelchair
- ☐ Non-Ambulatory

Personal Hygiene:
- ☐ Independent
- ☐ Special Needs _____

Oral Hygiene:
- ☐ Independent
- ☐ Special Needs _____

Head of Bed Elevated:
- ☐ Yes
- ☐ No

SPECIAL NEEDS

Usual Response to Medical Exams: ☐ Cooperates ☐ Partially Cooperates ☐ Resistant ☐ Fearful

☐ Sedation for clinical visits (Explain): _____

☐ Special positioning required for examination (Explain): _____

☐ Double staffing required for assistance with exams (Explain): _____

☐ Requires limited waiting periods for exams

☐ Prefers early day appointments ☐ Prefers end of day appointments

☐ Special communication device/method (Explain): _____

Pain Response: ☐ Normal ☐ Unique (Explain) : _____

MEDICAL PROVIDERS

Name:

Primary Care	**Subspecialist/Type:**
Name _____ Tel. # _____	Name _____ Tel. # _____
Address _____	Address _____
_____	_____
Dental Care	**Subspecialist/Type:**
Name _____ Tel. # _____	Name _____ Tel. # _____
Address _____	Address _____
_____	_____
Eye Care	**Subspecialist/Type:**
Name _____ Tel. # _____	Name _____ Tel. # _____
Address _____	Address _____
_____	_____
Subspecialist/Type:	**Subspecialist/Type:**
Name _____ Tel. # _____	Name _____ Tel. # _____
Address _____	Address _____
_____	_____

Living Status: ☐ Group Home ☐ Own Family ☐ Independent ☐ Home Sharing/Shared Home ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Other _____

Work/Day Program Status:

☐ Community Day Support ☐ Day Habilitation

☐ Regular job ☐ Sheltered workshop

Nursing Supports available:

☐ In home ☐ In home 24 hr

☐ Nursing Coordination ☐ Access to VNA

☐ No Nursing supports

IMMUNIZATIONS

Date of last TETANUS _____	☐ Unknown	☐ Allergic	☐ Never
Date of last FLU SHOT _____	☐ Unknown	☐ Allergic	☐ Never
Date of last PNEUMOVAX _____	☐ Unknown	☐ Allergic	☐ Never
Date of HEPATITIS B VACCINE			
Primary Series (3 shots) _____	☐ Unknown	☐ Allergic	☐ Never
Booster _____	☐ Unknown		☐ Never
Date of MEASLES/MUMPS/RUBELLA (MMR) _____	☐ Unknown	☐ Allergic	☐ Never

List any other vaccinations and date (e.g., Lyme, Hepatitis A, Varicella, etc.)

_____

TUBERCULOSIS SKIN TEST (PPD):

Have you ever had a positive skin test for tuberculosis? ☐ Yes ☐ No ☐ Unsure

If yes, was any treatment given? ☐ Yes (describe) _____ ☐ No (Explain) _____

Date of last PPD _____

PAST MEDICAL HISTORY

Name:

☐ **Medical History not released by parent/guardian.**

For information, contact: Name _____ Relation _____

Tel #_____ Address _____

SURGICAL:

List all previous surgeries and dates (most recent first):

_____

_____

_____

List any serious trauma or broken bones:

_____

_____

_____

Any previous problems with anesthesia? ☐ No ☐ Yes (describe)_____

GYNECOLOGIC (women only):

Age menstruation started _____ Age menstruation stopped _____ ☐ Still menstruating

Have you ever given birth to a child? ☐ Yes ☐ No

Date of last PAP smear _____ ☐ Unknown ☐ Never

Any history of abnormal PAP smear? ☐ No ☐ Yes (describe below) _____

Date of last mammogram _____ ☐ Unknown ☐ Never

MEDICAL: List all serious medical illnesses (e.g. pneumonia, heart attack) and ongoing medical problems (e.g., diabetes, high blood pressure, epilepsy)

_____

_____

_____

_____

PSYCHIATRIC: List all major behavioral & psychiatric diagnoses (e.g., depression, schizophrenia, self-injurious behavior)

_____

_____

_____

_____

PRIOR EVALUATIONS:

Date of last AUDIOLOGICAL EXAM _____	☐ Unknown	☐ Never
Date of last EYE EXAM _____	☐ Unknown	☐ Never
Date of last DENTAL EXAM _____	☐ Unknown	☐ Never
Date of last BONE DENSITOMETRY (checks bone thickness) _____	☐ Unknown	☐ Never
Date of last SIGMOIDOSCOPY or COLONOSCOPY _____ (scope examination of large intestine)	☐ Unknown	☐ Never
Date of last PSA (prostate cancer screening) _____	☐ Unknown	☐ Never

FAMILY HISTORY

FATHER: Deceased? ☐ Yes Age at death: _____ Cause of death: _____

☐ No Current age: _____

MOTHER: Deceased? ☐ Yes Age at death: _____ Cause of death: _____

☐ No Current age: _____

List all brothers and sisters with information about their age and health:

_____

_____

_____

Is there any family history of:

DIABETES	☐ Unknown	☐ No	☐ Yes
HIGH BLOOD PRESSURE	☐ Unknown	☐ No	☐ Yes
HIGH CHOLESTEROL	☐ Unknown	☐ No	☐ Yes
HEART DISEASE	☐ Unknown	☐ No	☐ Yes
OSTEOPOROSIS	☐ Unknown	☐ No	☐ Yes
COLON POLYPS	☐ Unknown	☐ No	☐ Yes
CANCER	☐ Unknown	☐ No	☐ Yes

What Type?_____

_____

Are there any other diseases that "run in the family"?

☐ Unknown ☐ No ☐ Yes (give details below)

_____

_____

_____

Has there been any genetic counseling in the family?

☐ Unknown ☐ No ☐ Yes (give details below)

Result: _____

_____